Head and Neck Surgery

The practice of Head and Neck Surgery must evolve to meet the needs of our patients while balancing the challenges we face during the COVID-19 pandemic. The majority of head and neck cancer care has fallen within the *urgent* category and patients have continued to get care at many centers. However, outpatient clinic visits for surveillance of cancer patients, flexible endoscopy to diagnose tumors in clinics and care for many non-mucosal tumors have been placed on hold in many centers that have been overwhelmed with COVID-19 positive patients. As the number of cases plateaus, we have to continue to prioritize care for our patients. The AAO-HNS Head and Neck Oncology committee together with the AHNS leadership (section leaders) have prioritized cases based on different subsites that are included below.

Stratification of common head and neck surgery cases by urgency. (Drs. Topf and Holsinger)

Emergent – Proceed with Surgery

Any tumor obstructing the airway or causing significant bleeding

Salivary gland or deep neck abscesses

Urgent – Proceed with Surgery

All SCC of the upper aerodigestive tract

Thyroid

- Anaplastic thyroid carcinoma
- Medullary thyroid carcinoma
- Large (> 4 cm) thyroid nodules with FNA cytology of Bethesda 3,4,5 or 6
- (PTC) with identified or suspected regional or distant metastasis.
- Locally aggressive PTCs demonstrated by fixation, posterior thyroid position, VC paresis/paralysis, hemoptysis
- Recurrent PTC with bulky or progressive disease
- Life-threatening or severely symptomatic Graves' that cannot be controlled medically
- Significantly symptomatic compressive goiter

Parathyroid

- HPT with Calcium >13 mg/dL, with active cardiac, renal or neuromuscular manifestations that cannot be controlled medically

Endocrine disorders in pregnancy dangerous to the health of the mother or fetus that cannot be controlled medically

Skull base malignancy

Salivary cancer

- Salivary duct carcinoma
- High-grade mucoepidermoid carcinoma
- Adenoid cystic carcinoma
- Carcinoma ex pleomorphic adenoma
- Acinic cell carcinoma
- Adenocarcinoma
- Other aggressive, high-grade salivary histology

Skin cancer
- Melanoma > 1 mm thickness
- Merkel cell carcinoma
- Advanced-stage, high risk squamous cell carcinoma
- Basal cell carcinoma in critical area (i.e. orbit)
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Time Sensitive– Consider Postpone > 30 days

Low-risk PTC lower volume without metastasis

Low-grade salivary carcinoma

Slower growing BCC

Routine– Consider Postpone 30 – 90 days; Reassess after pandemic appears to be resolving

Thyroid
- Goiter without airway/respiratory compromise
- Routine benign thyroid nodules and thyroiditis
- Recurrent PTC with low volume, stable or slow rate of progression

Parathyroid
- HPT with calcium < 12 mg/dL, without active cardiac, renal or neuromuscular manifestations

Benign salivary lesions and tumors

Skin cancer
- Melanoma ≤ 1mm thickness
- Basal cell carcinoma where cosmetic impact/morbidity is likely low with further growth
- Low-risk squamous cell carcinoma

Case-by-case basis

Rare histology with uncertain rate of progression
Diagnostic procedures, such as direct laryngoscopy with biopsy

SCC = squamous cell carcinoma; PTC = papillary thyroid carcinoma; HPT = Hyperparathyroidism: BCC = Basal Cell Carcinoma